

NAME: _____ DATE: _____ DOB: _____

REVIEW OF SYSTEMS: Please circle if you have *recently* experienced any of the following:

Constitutional

Fever

Eyes

Blurred Vision

Allergic/Immunologic

Drug Allergies

Environmental Allergies

Neurological

Dizzy Spells

Headache

Numbness/Tingling

Tremors

Gastrointestinal

Nausea/vomiting

Cardiovascular

Chest Pain/Angina

High Blood Pressure

Genitourinary

Back Pain

Bedwetting

Blood in Urine

Dribbling

Burning on Urination

Erection Problems

Flank Pain

Hematuria

Hesitancy

Kidney Failure

Kidney Infections

Kidney Stones

Leak after voiding

Nocturia

Nocturnal Enuresis

Not Emptying

Painful Ejaculation

Stones

Suprapubic Pain

Urgency

Urinary Frequency

Urinary Hesitancy

Urinary Incontinence

Urinary Tract Infections

Urine retention

Urologic Cancer

Urologic Surgery

Vaginal Bleeding

Vaginal Discharge/Problems

Weak Stream

Respiratory

Shortness of breath

Wheezing

Patient Signature_____

Date_____